Aftercare of State Hospital Patients

The Role of the General Practitioner

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■ *Of all the problems facing patients released from a state hospital, the most serious one is adjustment. Failure here means a return to the hospital. The present aftercare program of the Department of Mental Hygiene does not and is not intended to meet all of the patient's needs. It must rely upon other agencies to assist. It must rely upon the general practitioner to provide the continuity of care which is so important to successful rehabilitation.*

The general practitioner can often make return to a state hospital unnecessary by an accurate assessment of the patient's problems, by effective intervention, by utilizing available consultation and by judicious referral. When services are not available, he can do much to make them available through the effective use of his professional channels.

LAST YEAR there were about 27,000 admissions to the California state hospitals for the mentally ill, and more than 31,000 releases. Many of those released will be faced with a return to hospital in the future if they cannot make a satisfactory readjustment.

The management of this large number of persons in their post-hospital adjustment is an extensive problem. The inadequacy of present methods of management is reflected in the number of returns to the hospitals. The role of the general practitioner in the management of these patients varies considerably at present. Development of existing potential depends upon the image that the general practitioner has of himself and the value he ascribes to the services he has to offer the psychiatric patient. The value should be assessed in the light of the kinds of people requiring service, the problems they face, what needs to be done and what facilities and services are available to do the job. Once the value is established, the role of the general practitioner depends upon how far he can extend his services. This, only he can decide. I will therefore attempt to define the scope of the problem, say what is now available and present some guidelines that may assist in making such an evaluation.

Who are the people being released from our state hospitals and what problems do they face? They have the normal everyday needs common to all of us. In addition, they have the problem of reestablishing themselves in a complex society. Some are children whose behavior had become so disturbed that their families and friends could no longer cope with them. Now, having been discharged from a hospital and still dependent on their parents, they must face a difficult readjustment period at home and at school, in addition to

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the normal stresses. Others are adults who, when they entered the hospital, left their home, job and friends behind. They now have to face an environment that has undergone change, just as *they* have undergone change. Still others are the elderly persons with concurrent physical disabilities. These physical problems add an even greater burden to the already serious emotional and social stresses they must face. Others may have specific problems such as alcoholism or dependence upon habit-forming medications. While they may have recovered from the toxic physiological effects, they still carry with them a latent emotional dependence that may again become overt as they have to face future stresses.

The nature of the patient's readjustment problem will vary with the length of stay in hospital.

When a person is released from a state hospital, he often finds himself in an unenviable position. Once the road to the state hospital is known, future trips can occur with less hesitation. Once a person has been in a hospital, returning to it can become the preferred alternative selected for him by others if he cannot conform to their expectations, regardless of how the patient himself may feel about it. This is true not only of relatives, but, unfortunately, of professional persons in his environment because this path may be more expedient. Instead of receiving assistance in meeting the additional problems of readjustment, the patient may face another admittance to hospital.

In reviewing some of the reasons for return to hospital, we often find that they are the same as those for which the patient was put in a hospital in the first place. While mental illness and emotional disturbances are not related solely to stress, it is useful to think in terms of psychiatric disorders as reflecting an individual's inability to cope with stress. Conversely, mental health may be considered a reflection of the individual's ability to cope with life stresses both external and internal. Symptoms of mental and emotional disorders, therefore, can be considered expressions of the person's attempts to deal with these stresses.

The state of decompensation that may result does not exist in a vacuum. The person is a social, psychological and biological member of a family and a community. Any change in his equilibrium disrupts not only himself, but also his family and community. When an individual's reactions become so extreme as to threaten the family or community, he may well become a candidate for return to the hospital. But that may not be necessary if appropriate resources for alternative care and treatment are available. This would include all medical resources from the general practitioner to the local public or private psychiatric hospital. These resources must not only be generally available, but available to the patient when he needs them. A psychiatric clinic with a six months' waiting list may be across the street, but do him no good. Return to a hospital may then become the only avenue of treatment, despite the fact that he must again leave his family, job, friends and community.

Often the disturbance of equilibrium which the patient faces occurs not because of his inability to cope with normal stresses, but because of the added stresses his environment places upon him. In such circumstances, proper identification of the problem may reveal that family counselling, referral to a local welfare or employment agency, or referral to an attorney for domestic or civil matters is the desirable alternative to readmittance to the hospital or out-patient psychiatric treatment.

When a person can no longer maintain his social and emotional equilibrium, despite the assistance of available professional services, return to the state hospital is indicated. The decision to return will vary in accordance with the severity of the illness and with the medical resources available. If the patient resides in a metropolitan center, the decision may be different than if he resides in a rural area several hours away from the nearest medical facility.

Whenever return to a state hospital is indicated, there are certain factors that must be considered. Hospitalization in itself, whether in a state hospital or elsewhere, is but one step in the patient's treatment. The illness begins when the patient is at home. Treatment must begin there as well as end there. Just as with any other illness, hospitalization alone cannot be the answer. Just as with any other illness, continuity of care should start and terminate with the family physician. All too often, for many reasons, this is not the case today.

To be put in a state hospital is a severe dislocation of the patient from his environment. It is a rupture with his family and home. While absent, he must often maintain related responsibilities with little or no way of meeting them. It is a rupture with his occupation. He must take extended sick leave or perhaps an even more drastic step—resign and hope to obtain new employment on his

release. It is a rupture with the way of life which he has developed over many years.

To minimize the need for return to the hospital and to assist the patient in re-establishing himself, the California Department of Mental Hygiene has developed a program of aftercare services. Social casework follow-up is available through periodic visits and emergency contacts with psychiatric social workers in 27 field offices throughout the state. The patient can obtain assistance in meeting his employment, educational, financial and recreational needs as well as in working through specific emotional and interpersonal problems with which he may be confronted. Should the patient not have any social resources and be unable to care for himself without supervision, arrangements are made for appropriate foster care or nursing care and additional supervision as long as is neded. Medical follow-up is provided at each hospital through its aftercare facility. In major population centers a psychiatrist provides consultation to the Bureau of Social Work staff, and also gives medical supervision primarily to posthospital patients on tranquilizing medication.

To obtain maximum success in the rehabilitation of the mentally ill patient, services must be provided as early as possible, with as much continuity as possible, as close to home as possible and with as much social restoration as possible.

Continuity of care implies that the same key people remain involved throughout the patient's course of treatment. Multiple referrals confuse the patient besides duplicating and diffusing efforts and wasting valuable time. The first professional person called at the onset of an illness is usually the one with the broadest and most general knowledge, and, as such, is best qualified to provide the continuity of care. A logical priority then develops as to who should provide the patient with the appropriate care and treatment. First priority is the private practitioner; local private or public agencies the second; state agencies the third.

The Department of Mental Hygiene's follow-up program is a third priority service, although often used as a first priority service. These follow-up services provide much-needed support to the patient who has no other available resources. These services are limited, are not intended for indefinite care and are established to fill an important gap. They cannot provide the intense, individual, total medical care that is the province of the general practitioner.

Where the general practitioner is available, either through his services to the patient or the family, he becomes the key person to provide the medical follow-up. Having the trust and confidence of the family and patient, and being the most easily available medically responsible person, he significantly influences how early the patient receives treatment, how much continuity of care is given, how much dislocation from his home the patient is to endure, and eventually how much social restoration is possible.

In the final sense the general practitioner can determine the success of rehabilitation.

It may well be time for the general practitioner to reassess the value of his services to the psychiatric patient. The management of the post-hospital patient provides an unequaled opportunity to do this. Although the patient has had a psychiatric disorder, there has been, as well, enough remission in the symptoms that he is ready to reestablish himself in his previous environment. Records are available of his illness, his treatment and his course in the hospital. Consultation is available for the future management of emotional problems.

In the management of the post-hospital patient, just as with any patient being treated for a psychiatric disorder, there are four factors to consider: Identification of the problem, intervention, consultation and referral.

1. *Identification of the Problem.* The patient must be assessed as a biological, psychological and social entity. Problems occurring in one area give rise to concomitant problems in others. Any diagnosis that is made should take into consideration the physical, emotional and social factors. It should, as well, clearly identify the nature of these components, the extent to which they are affected as well as the manner in which they are interrelated.

A thorough diagnostic work-up in the aged is of particular importance. An accurate identification of the problem areas is the first step in preventing a return to the hospital.

2. *Intervention.* Maintaining the physical health of the patient and correcting any physical disease is an important factor in successful rehabilitation. The confusion, apathy, disorientation and agitated behavior found in elderly persons are symptoms that often lead to psychiatric hospitalization. These symptoms often have their origin in correctable physical disease. Treatment of diabetes or of cardiac failure, reassessment of medication or reevaluation of diet can often control these

symptoms well enough that return to a state hospital becomes unnecessary.

Should admittance to hospital become indicated, treatment of the patient in a general hospital near his home may be a far better solution than return to a state hospital. This holds true not only for the elderly, but also, for example, for alcoholics. Detoxification need not take place in a state hospital. It could just as well be achieved in the local general hospital if it is available for the purpose.

Management of emotional problems need not always require the services of a specialist. The appropriate use of psychotropic medication and realistic support can do much in helping a person cope with existing stresses or face additional stress, or eliminate stress that may be detrimental. Recognizing the patient's problem and his reactions to them, allowing him to unburden himself of his fears and anxieties, and helping him to obtain perspective about the possible ways in which he can cope with stress are not tools just limited to the specialist. They are an important part of the everyday armamentarium of the general practitioner. The support of realistic reassurance and helping the patient utilize the healthy aspects of his personality cannot be underestimated in assisting him to achieve stability with his environment. Of particular importance in the patient released from a state hospital is seeing that other people in his immediate environment have a realistic image of the patient and their relationship to him. This is just as important as the necessity that the patient have a realistic image of himself and others. This means not only working with the patient but often with his family as well.

Helping the family relieve their own anxieties and fears about the patient can do much to prevent an additional unnecessary burden being placed upon him and perhaps another hospitalization.

3. *Consultation.* To the physician, effective use of the specialist's consultation is often the difference between continuing with the management of the patient and referring him to another resource. To the patient it often means the difference between receiving his treatment from someone he knows and trusts and having to face another stranger or group of strangers, go through another evaluation and assessment and develop another treatment relationship. To the post-state hospital patient it often means the difference between staying in his community or returning to the hospital.

Providing direct services to post-hospital patients, who can get no other services, has been a function of the Department of Mental Hygiene's after-care program. Consultation to the general practitioner as a part of this service is even now available from the hospital, its aftercare facilities, and its psychiatrists in major population centers. Information about the patient's social adjustment and about community agencies which may be considered potential referral resources is available from the Bureau of Social Work offices. The availability and effective use of these consultation and information services may well make the difference between the patient's making a successful readjustment and returning to the hospital.

4. *Referral.* The need for basic or more specialized services, either as an alternative to present care, or as a component of a multiphasic approach to the patient, constitutes the major reason for referral.

These services may be in the realm of intensive psychiatric intervention. They may also be such services as those required to meet the patient's educational, employment, recreational, financial, or residential needs.

Judicious referrals are a help to the patient; unnecessary referrals confuse him, irritate him and waste time. The safest approach to an effective referral is through appropriate consultation. Specific and effective referrals can be made, through the use of state agency offices such as the Department of Mental Hygiene facilities previously mentioned, and the use of local community mental health agencies and programs.

The most important element of the referral, however, is the fact that the patient, while receiving the specialized services, should remain the physician's patient. If the patient must leave the community and return to a state hospital, the major link which can assure any continuity of care is his family physician.

Should the needed services not be available, then the physician has another responsibility. Through the professional channels available to him, he should make his needs known and participate in planning and developing the services that are needed.

This is a joint responsibility that we have to facilitate our treatment efforts and most of all to protect the patient's welfare.

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